Kansas Department for Aging and Disability Services **Standard Intake & Information Form**

PSA: **Interviewer:** **Date:** **Intake Type:** ☐ **CARE** ☐ **In-Home Services**

Needs Relate to: ☐ FE ☐ PD ☐ TBI ☐ Other:

Intake Source: ☐ 3160 ☐ Telephone – Customer ☐ Telephone – Family / Provider ☐ Other

CUSTOMER INFORMATION

Customer Name: **Birth Date**: Age:

Social Security # KAMIS #: Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Veteran: ☐ Yes ☐ No

Spouse Name: Spouse Birth Date:

Has a medical card: ☐ Yes ☐ No If yes, #:

Applied for HCBS/Medicaid: ☐ Yes ☐ No When (date): Approved for Social Security Disability: ☐ Yes ☐ No

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Ethnicity Missing

Interpreter Needed: ☐ Yes ☐ No

If yes, specify language:

Race:

☐ White Non-Hispanic ☐ Black or African American

☐ White Hispanic ☐ Native Hawaiian or Other Pacific Islander

☐ American Indian/Alaskan Native ☐ Reporting some other race

☐ Asian ☐ Reporting 2 or more races

ADDRESS INFORMATION

Address:

Street *City* *County* *State* *Zip*

Phone: Phone (alternate): Email:

ASSOCIATE INFORMATION

Does the customer have a legal guardian? ☐ Yes ☐ No ☐ Unknown

Emergency Contact: Relationship: Email:

Name: Phone: Phone (alternate):

Address:

Street *City* *County* *State* *Zip*

Emergency Contact Living with Customer: ☐ Yes ☐ No Emergency Contact Primary Caregiver: ☐ Yes ☐ No

CUSTOMER'S CURRENT LOCATION

☐ **Home** ☐ **Nursing Facility** ☐ **Hospital** ☐ **Prison** ☐ **Other**:

If Facility or Hospital – complete name and address

Admission Date: Expected Discharge Date:

Name:

Less Than 30 Day Admission: ☐ Yes ☐ No

Emergency Admission: ☐ Yes ☐ No

Street *City* *State* *Zip* *Phone*

Terminal Illness or Coma Diagnosis: ☐ Yes ☐ No

PASRR (Required for CARE)

Does customer have a history of MI or ID/DD or related condition? ☐ Yes ☐ No If Yes, which: ☐ MI ☐ ID/DD ☐ Related condition

Is a CMHC involved? Is a CDDO involved? ☐ Yes ☐ No

Case Manager Name: Agency Name/Address:

Case Manager Phone:

NEEDS (CHECK IF APPLICABLE)		RISK FACTORS (CHECK IF APPLICABLE)	
☐ Bathing	☐ Shopping	☐ Animals in or around home	☐ Infectious Disease
☐ Dressing	☐ Toileting	☐ Bladder/Incontinence	☐ Lives Alone
☐ Eating	☐ Transfer	☐ Criminal Record	☐ Memory/Difficulty
☐ Laundry/Housekeeping	☐ Transportation	☐ Depression	☐ Neglect, Abuse, Exploitation
☐ Management of Meds/Treatment	☐ Use of Telephone	☐ Falls, Unsteadiness	☐ Support, Caregiver not available
☐ Meal Preparation	☐ Walking, Mobility	☐ Hearing Impairment	☐ Visual Impairment
☐ Money Management			

Is customer aware of the referral? ☐ Yes ☐ No Does customer agree to the referral? ☐ Yes ☐ No

Referred By: Relationship: Phone:

Most significant concerns / health problems:

Current services / providers:

FINANCIAL

Family Size:

Assets Above:

$10,000 (1 person) ☐ Yes ☐ No

$13,500 (2 persons) ☐ Yes ☐ No

Income Sources:	Customer		Spouse	
SSA				
SSI				
Other				
Total		+		=

CUSTOMER REFERRAL

☐ Assessment Assessment Type: ☐ HCBS ☐ OAA ☐ SCA ☐ PACE Due Date:

☐ APS/CPS ☐ CIL ☐ CDDO ☐ I&A/OC ☐ Mental Health

Information Mailed:

Comments:

I & A			
Date	***Units***	***Date***	***Units***